Yorkshire Ambulance Service NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Letter from the Chief Inspector of Hospitals

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from

Summary of findings

isolated moors and dales to urban areas, coastline and inner cities. The trust employs over 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and Emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

Our inspection of the ambulance service took place between 12 to 15 January 2015 with unannounced inspections on 19 January 2015 and 9 February 2015. We carried out this comprehensive inspection as part of the CQC's comprehensive inspection programme.

We inspected four core services:

- Emergency Operations Centres
- Urgent and emergency Care
- Patient Transport Services
- Resilience Services including the Hazardous Area Response Team:

Overall, the trust was rated as requires improvement. Effectiveness, safety, responsive and well-led were rated as requires improvement. Caring was rated as good.

Our key findings were as follows:

- At the time of inspection four out of the six executives were in substantive positions however there had been a recent loss of the Chief Executive and a history of change at executive level within the trust. .
- There was below national average performance over Red 1 and 2 targets and an increased number of complaints which did not meet the trusts 25 day response times. The trust reported during this period an increase in activity across all services.
- The trust were in the process of changing the culture in the organisation from performance target driven to one of professional/clinical culture.
- There was a history of poor staff engagement and relationships between senior management and workforce. There was a recent introduction of new rotas and meal breaks had a further negative impact on relationships.
- We had significant concerns within the HART service about the checking of equipment, a large number had passed its expiry date and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns.
- Development work had been undertaken to strengthen the assurance and risk management process and these showed improvement, but lacked maturity. Issues were found on inspection for example there were security issues at one station, cleanliness of ambulances across the region, but particularly at the HART unit demonstrate a lack of robustness with misleading results giving rise to false assurance.

The trust had major difficulties in recruiting staff, national shortages of paramedics contributed to the trusts difficulty in recruiting paramedics which impacted on the ability to be responsive and also enable staff to attend training and other activities.

The trust was working hard to be more outward facing, working in partnership with commissioners and improving consultation with patients and public.

We saw several areas of outstanding practice including:

For the trust:

- The trust's 'Restart a Heart' campaign trained 12,000 pupils in 50 schools across Yorkshire.
- The trust supported 1,055 volunteers within the Community First Responder and Volunteer Care service Scheme.
- Green initiatives to reduce carbon in the atmosphere by 1,300 tonnes per year.
- The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.
- Mental health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

However, there were also areas of poor practice where the trust needs to make improvements.

Summary of findings

Importantly, the trust must:

- The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure that equipment and medical supplies are checked and are fit for purpose.
- The trust must ensure all staff are up to date with their mandatory training.

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should all staff have received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate translation services available for staff to use to meet the needs of people who use services.

In addition, the trust should consider other actions these are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employs over 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million. YAS is the only NHS trust that covers the whole Of Yorkshire and Humber.

The trust provided an accident and emergency (A&E) service to respond to 999 calls, patient transport services (PTS) and Emergency operation centres (EOC) where 999 calls were received clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART). The trust also provided an NHS 111 core service for when medical help is needed fast but it is not a 999 emergency. This core service was not inspected as part of this inspection and will be inspected separately.

In 2013-14 the trust's A&E service responded to 795,750 urgent and emergency calls and received through the EOC 2.2 million 999 and NHS 111 calls per year which averages at 2,180 calls per day. Within PTS in 2013-14 the service made around 886,312 journeys transporting patients across Yorkshire and neighbouring counties each year.

The trust covers a population of approximately five million people and ethnic diversity ranged from 1.9% to 18.2% of the population. Within West Yorkshire, South Yorkshire and Kingston upon Hull area the life expectancy for both men and women was lower than the England average. Whereas in North Yorkshire the life expectancy was higher than the England average for both men and women.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers

Head of Hospital Inspections: Julie Walton, Care Quality Commission

A team of 51 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists: The team of specialists comprised of paramedics, urgent care practitioners, operational managers, call handlers and experts by experience that had experience of using services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services

Summary of findings

• Resilience Team including the Hazardous Area Response Team

Prior to the announced inspection, we reviewed a range of information that we held and asked other

Organisations to share what they knew about the hospital. These included the clinical commissioning

Groups (CCGs), the Trust Development Authority, NHS England, and the local Healthwatch's.

We held focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with patients and staff from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 13–15 January 2015 and undertook unannounced inspections on 19 January 2015 and 9 February 2015.

What people who use the trust's services say

Friends and Family Test

In October 2014 95% of patients who responded the friends and family test would recommend the service to a friend or family member.

Hear and Treat Survey 2013-2014

The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 25 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 16 questions, and better than other trusts for nine questions. This meant overall the trust was the best performing trust in this survey.

Patient surveys

The patient Survey for the (EOC) in October 2014 showed 87.3% of patients felt the ambulance call taker listened carefully and 86.7% of call takers were reassuring.

For PTS the trust patient experience survey for August 2014 showed 100% of patients said they had been treated with dignity and respect within each of the regions.

The trust's patient experience survey for August 2014 also showed between 66% – 80% of patients across the four regions would be 'extremely likely' or 'likely' to recommend PTS to family and friends if they required transport to hospital.

A&E Patient survey

In the Yorkshire Ambulance Service - A&E Service User Experience Survey Report for April 2014 to November 2014 for the question I understood my care and treatment the trust has scored 95%. For the same time period 92% would recommend the service to a family member or friend.

Patients views during the inspection

During the inspection, we spoke with a number of patients across all services. Patients also contacted CQC by telephone and wrote to us before and during our inspection. The comments we received were mainly positive about their experiences of care. The main concerns raised with us were in relation to delays in transport for patients using PTS.

Facts and data about this trust

The population the trust serves includes:

- South Yorkshire
- North Yorkshire
- Hull & East Yorkshire
- West Yorkshire

Yorkshire Ambulance Service NHS Trust also provides a 111 service to:

- Bassetlaw
- North Lincolnshire.

Activity

Summary of findings

- In 2013-14 the trust's A&E service responded to 795,750 urgent and emergency calls.
- The total number of calls for 999 and NHS 111 handled by the trust was 2.2 million calls per year which averaged at 2,180 calls per day.
- Within PTS in 2013-14 the service made around 886,312 journeys transporting patients across Yorkshire and neighbouring counties each year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? A Trust Board paper from the Audit Committee (8 January 2015) identified one of the key risks reported was regarding the adverse impact on clinical outcomes and operational performance due to inability to deliver the A&E workforce plan and associated recruitment and training requirements. It stated this remained a key risk to delivery and further work was on-going in early 2015 to update the plan. Within the trusts Quality Accounts 2014 it stated an internal review found a need to better match resources to current and future demand profile, particularly evenings and weekends. In March 2014 the trust introduced new rotas and rest break arrangements and revised some of the practice policies. The five year workforce plan was reviewed and educational provision identified to include a student paramedic programme, advanced practitioners programme, emergency care programme, a range of professional development courses for example sepsis, EOL and domestic abuse. We had significant concerns within the resilience service specifically the HART team about the checking of equipment, a large number had passed its expiry date and assurance processes had not detected this. There were also inconsistencies with checking of breathing apparatus and the processes observed did not follow best practice guidance. An external audit report of the HART service produced in November 2014 highlighted areas for improvement in relation to equipment including checking of equipment. It was recommended that equipment should be checked on a regular basis to ensure all of the necessary equipment is on board the vehicles in case of an emergency call out. However at the time of our inspection these improvements had not been implemented. In addition there was equipment that had not been appropriately charged so would not be ready for use. The command vehicle had been connected to the electricity supply however when the vehicle was started the backup generator was running which suggested all systems were not fully charged. Therefore the vehicle would not be ready to dispatch if required and there had been confusion as to how the vehicle should be connected to the electrical supply. The Automated External Defibrillator on the vehicle showed it was not ready for use and had not been suitably charged.	**Requires improvement**

Summary of findings

The HART team at the Leeds location had six breathing apparatus (BA) sets and these should have been checked at the start of every shift. We were informed that the number of BA sets checked was dependent on the number of HART paramedics on duty and a minimum of four BA sets should be checked per shift. We noted that on one vehicle, two of the four sets had not been checked that day; one set had been checked the day before and the other set two days before.

These concerns were escalated to Executive director of operations for the trust to address. We re-visited the HART base two days after the announced inspection and one month later to check that changes had been implemented in response to our concerns. We found the management team had implemented a range of measures to ensure systems were in place for the checking of equipment. We saw processes had been improved for ensuring breathing apparatus was checked at the beginning of every shift and gas cylinders were stored separately including a having a separate rack for Oxygen, Entonox and empties. The inventory list for all vehicles had also been revised and was easier to follow and audit against.

The HART team was part of the National Ambulance Resilience Unit (NARU) which was established in each ambulance trust to help strengthen national resilience and improve patient outcomes in a variety of challenging pre-hospital environments. Each HART team had to provide assurance 24 hours a day seven days a week they are prepared and able to respond. However during our inspection we found this was not the case.

Concerns regarding equipment, stock management and assurance processes were also identified within the urgent and emergency care service with out of date stock found in ambulances and at ambulance stations.

During the visit the inspection team were able to walk into one ambulance station without being challenged or noticed. We found the station to be unsecure and the inspection team were able to gain open access to the station and to the ambulances in the parking bay

There was a lead person in the role of director of infection, prevention and control (DIPC), who was supported by one infection prevention nurse. The DIPC and nurse were also supported by Associate Director of Risk and safety and members of the Risk and Safety team. Any infection issues were discussed at the incident review group, which had representatives from clinicians, the 111 service, human resources, legal and representatives from operations.

Summary of findings

Monthly audits for infection control took place however during the inspection however there were variable standards of cleanliness, infection control and hygiene across the areas visited. This was particularly relevant for ambulances in the HART/ resilience team and the urgent and emergency care services. Vehicle cleaning was rated as a high risk on the corporate risk register control measures had been put in place and this had reduced the risk to moderate. Due to findings in these services the trust could not rely on the effectiveness of the internal audit reports, particularly over cleanliness and that the control measures had reduced the risk.

Observations during the inspection showed some staff wore wrist watches. The trusts infection prevention and control policy dated 12 February 2014 stated that any watch worn had to be waterproof and washable which was in line with what staff reported. However the trust policy did not contain guidance on how often wrist watches should be decontaminated or cleaned. This was not in line with current best practice which consider that bare below the elbows means that all staff in contact with patients could effectively decontaminate their hands and wrists between each episode of patient care or contact which is not possible to do properly when wearing cuffs, watches and/or jewellery.

The NHS Safety Thermometer is not relevant, in some areas, such as ambulance Trusts but we asked about the processes for harm measurement and reporting. We found the Trust produced a monthly safety thermometer briefing and included the number of harm free days and incidents relating to the patient transport service (PTS) and Accident and Emergency (A&E) service. Within PTS services we saw information on the safety thermometer for January 2015 indicated two of the reported falls were being investigated due to the severity of the fall. One of the falls had not been reported and had been brought to the trust's attention via a complaint. There was information on the safety thermometer sheet which reminded staff to report incidents as soon as possible.

The trust had developed a policy for duty of candour and being open. The policy statement stated that

"All staff including volunteers, working for YAS are required to be open with patients. It is an essential part of us achieving a culture of safe care identifying lesson, which need to be learned." The trust had a log with current cases which were seen at the inspection.

For full details, see the location report for the inspection of this provider.

Summary of findings

Are services at this trust effective?

Requires improvement

The trust used national evidenced-based guidelines to prioritise and categorise emergency calls based on the clinical needs of patients. The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.

The trust had Mental health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

There were a number of alternative urgent care pathways in line with the recommendations of the Urgent Care Review 2013 by Sir Bruce Keogh. It was recommended that by treating patients at the scene and reducing conveyance rates the ambulance service would contribute to alleviating some of the pressures in emergency departments and offer a better service to patients. These had been developed through partnership working with other providers and included direct referral to specialist teams such a respiratory teams.

The 2013/14 Hear and Treat Survey contacted adult callers who had received telephone triage and advice when calling 999 in December 2013. The survey consisted of 25 questions relating to the call handler, clinical adviser, outcome and overall impression of the service provided. The trust performed, on average, the same as other ambulance trusts for 16 questions, and better than other trusts for nine questions. This meant overall the trust was the best performing trust in this survey.

The trust was better than expected for the number of stroke positive patients who received the appropriate care bundle. A stroke positive patient was identified as showing FAST symptoms. In August 2014 57.3% of patient arrived at a stoke unit within 60 minutes below the England rate of 60.4%. For ST segment elevation myocardial infarction (STEMI), which is a type of heart attack, the trust was the best performing trust for patients receiving an appropriate care bundle at 85%.

The trust was one of the worse performing ambulance trusts at 23% for patients who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. That is, reviving a patient when their heart had stopped. The highest performing trust was 40%. The trust was the second highest performing trust for the overall cardiac survival rate for patients who have a cardiac arrest survival to discharge. The trust performed similar to expected for the proportion of patients who received treatment in hospital within 150 minutes.

Summary of findings

In 2013-14 the trust had a mixed performance against the England average for Red1 calls but over the year performed better than the England average, particularly between July and November. In the first two quarters of 2014-15 the trust had performed worse than the England average rarely getting over 70% of Red 1 calls responded to within 8 minutes. In 2013-14 the trust performed slightly better than the England average, for response times to Red 2 calls only performing worse in quarter four. In the first two quarters of 2014-15 the trust started worse than England averages, however had started to match the England average at the end of quarter 2 with response rate of 70%. For all category A calls resulting in the arrival of an ambulance at the scene of the incident within 19 minutes the trust performed better than England average and did not breach the 95% target during 2013-14. The trust had also performed better than England average and did not breach the 95% target during the first six months of 2014-15.

Within the EOC business plan December 2014 it stated the call pick up time was above the standard of 95% in 5 seconds with the year to date position being 95.3%.

Within PTS services during April to October 2014, there were 662,888 actual patient journeys against a planned number of 663,148 journeys. The thresholds for compliance against each key performance indicator were different for each CCG dependent on historic performance, activity profiling targets and historic funding streams. As a consequence compliance in one area was not equitable with performance in another. Trust data by region for patients arriving on time for their appointment during quarter two (July-September 2014) showed: East Yorkshire 74.9% (target 77%), North Yorkshire 77.3% (target 82%) South Yorkshire 86.4% (target 90%) and West Yorkshire 85.1% (target 82%). There were 92.8% of patients who were collected within 120 minutes (on the day and at short notice journeys) against a target of 93.8%.

Performance indicators for renal patients showed targets were not being met for inward arrival times and outward collections within 60 minutes of ready time.

For full details, see the location report for the inspection of this provider.

Are services at this trust caring?

Good

Patients were treated with compassion, dignity and respect by ambulance staff. Staff explained treatment and care options in a way that patients could understand; they explained and involved patients in decisions. Patients were supported to manage their own

Summary of findings

health by using non-emergency services when it was appropriate to do so. Patients, their relatives and others received emotional support when experiencing distressing events, including when someone had died.

Patients and hospital staff spoke positively about the quality of staff. We observed crews on PTS vehicles assist patients and explained procedures to them on accessing the vehicle and during their journey. Crews ensured patients were safely escorted to the hospital department or their home and made comfortable.

For full details, see the location report for the inspection of this provider.

Are services at this trust responsive?

Requires improvement

The trust had five specific vehicles which had an enhanced range of equipment available for patients considered to be bariatric or obese. These had been introduced as an improvement beyond the basic capability of the existing fleet. However staff told us these ambulances were not always able to respond in a timely way for emergencies and described incidents where the patient's dignity had to be balanced with the need for emergency care.

In 2013/14, the trust had 14.6% of all Red 1 calls in England and 9.1% of all Red 2 Calls in England. The trust had been dealing with a steady number of calls since 2012; in April to September 2014, the trust had 15% of Red 1 calls and 9.3% of Red 2 calls in England.

For the PTS service patients and hospital staff in North, East and West Yorkshire told us they had difficulty in getting through to the control centre to book or cancel appointments. One patient said they had waited 45 minutes to book a journey another said they had tried to make a booking by phone on the 0300 number many times but could not obtain an answer; instead they had contacted the hospital who made the appointment for them. PTS call data up to October 2014 confirmed the target of 80% of calls were not being answered within 30 seconds.

PTS for renal dialysis patients did not always meet prescribed response time targets in line with The National Institute for Health and Care Excellence (NICE) quality standard 15: Patient Transport (March 2011). The guidance stated that patients with chronic kidney disease receiving haemodialysis or training for home therapies should have transport within 30 minutes of their clinical treatment. Records for patients receiving dialysis in York showed that over a six month period, 21 patients had waited more than 60 minutes after their treatment had finished and seven had waited more than two hours. This impacted on waiting times and hospital staff who sometimes had to stay later than their contracted hours to

Summary of findings

accommodate patients. Targets for renal arrival times were not being met effectively. Records for York renal dialysis unit showed between 21 August 2014 and 5 January 2015 five patients arrived earlier than the 60 minute standard and 15 patients had arrived late for their dialysis with the greatest delay being two hours after the appointment time. This was also the case for West Yorkshire and Hull area renal patients; targets were not being met for inward arrival times and outward collections within 60 minutes of ready time.

There were examples of Resilience planning and suitable on-going assessments of service demand and pro-active planning. If HART staff were attending an operational job, they were promptly relieved to attend a Resilience call-out if necessary. Due to the issues regarding stock and equipment there was concern that the responsiveness of the Resilience function, including HART, had been compromised. This, potentially, could have had a negative impact on being able to provide a swift response to Resilience / HART related call-outs.

The trust was the first ambulance trust to receive “working to become dementia friendly” recognition by the Dementia Action Alliance.

The trust used the four C’s as measures for quality; these were complaints, concerns, comments and compliments. Staff were encouraged to resolve complaints informally where possible, but if there were trust wide issues then these would be escalated to investigation. Complaints were audited monthly using a criterion based on the Patient Association and also a peer ambulance service. The latter enabled a comparison of results across two trusts.

There had been an increasing number of complaints which had not been responded to within the trust’s 25 day target. The trust was achieving the timescales in 60% of cases. At the time of the inspection, there was a back log in operations of around two months, which equated to about eight cases. The trust had revised the policy, changing the target response time to reflect the complexity of the complaint.

Themes from complaints for the PTS service generally were twofold, delays in picking patients up following appointments and delays in picking up at home. The themes for the EOC were generally around the coding of calls and the timing of response. An audit of calls had been undertaken to highlight any cases that needed escalating to the incident review group.

For full details, see the location report for the inspection of this provider.

Summary of findings

Are services at this trust well-led?

Requires improvement 

The trust had a mission statement and a trust strategy. The trust strategy was based on four themes with one mission, Saving lives, caring for you. The trust was facing challenges due to the number of interim posts in the senior management team. The trust's previous Chief Executive had recently resigned, which left only the Chair and three substantive members of the executive team, other posts were on an interim basis only.

The trust governance arrangements comprised of two leadership groups, the Trust Board and the Trust Executive Group, with a range of committee and subgroup structures between and beneath these. The latest version of the Board Assurance Framework was agreed in October 2014 and further updated in December 2014. The strategic objectives on the BAF were underpinned by the risk registers and used to support objectives for the business planning cycle and the annual governance report. Risks to meeting performance targets included attending red calls were considered high. When we visited the resilience team, including the HART service, we found that there were governance failings to ensure that the equipment, including lifesaving equipment and consumables were safe to use, with in-date products and appropriately charged.

Staff reported across the trust that promotion to management had traditionally been through the ranks, with performance targets the main driver rather than quality. It was clear through interviewing the executive team, senior managers and professionals working within the trust that there was an ambition to move to a professional, clinical culture. Before, during and after the inspection staff side representatives raised concerns about safety and performance at the trust

Vision and strategy

- The trust had a mission Statement and a trust vision "Providing world-class care for the local communities we serve". The trust had developed a set of values and behaviours based on an acronym We Care which stood for Working together for patients, Everyone counts, Commitment to quality of care, Always compassionate, Respect and dignity and Enhancing and improving lives.
- The trust strategy was based on four themes with one mission, saving lives, caring for you. The four themes to achieve the mission statement were, "Right care, right place, first time; Right skills for patients; Exceeding expectations and spending public money wisely and Engaging and involving communities and staff in change.

Summary of findings

- The trust strategic objectives were delivered through the trust's five year Integrated Business Plan, which was underpinned by a two year Operating Plan which covered 2014-2016. This was also underpinned by directorate and departmental plans to support this.

Governance, risk management and quality measurement

- Yorkshire Ambulance Service covered the whole of Yorkshire and some of north Lincolnshire. It provided services across South Yorkshire, Leeds and Wakefield, Hull and East Riding, Bradford, Calderdale and Kirklees, North Yorkshire and Craven, with emergency operation centres based at Wakefield and York. The trust provided services to 16 acute NHS trusts and seven mental health trusts.
- The trust governance arrangements comprised of two leadership groups, the Trust Board and the Trust Executive Group, with a range of committee and subgroup structures between and beneath these.
- There were five main committees reporting to the Trust Board, which consisted of the audit committee, the finance and invest committee, the quality committee, the remuneration and terms of service committee and the charitable funds committee.
- Working to the Trust Executive team were five groups, the performance review group, the cost improvement management group, the trust management group, the foundation trust development group and the TEG transformation group (this covered the urgent care, estates/ hub and spoke, organisational development and leadership aspects for the trust).
- A range of subgroups and committees were delegated specific operational and delivery work and included a workforce group, clinical governance group (the patient safety group, the incident review group and the medicines management group reported into the clinical governance group), risk assurance group (also contained the information governance group), health and safety committee and an estates, fleet and equipment group.
- There were arrangements in place across the operational delivery of the trust and were arranged into three groups which specialised in their service area, a patient transport management group, accident and emergency operations management group and the NHS 111 management group.
- Working to the operational delivery groups were locality management groups who were responsible for the daily local operational management and reporting.
- Changes in appointment and recruitment to key posts was on-going, some of which played a role in the mitigation of risk. For

example, a Trust Board paper from the Audit Committee (8 January 2015) provided the quality committee risk assurance report. One of the key risks reported was that of the adverse clinical outcomes due to failure of reusable medical devices and equipment. A reduction in risk was stated as "contingent" on the recruitment of a new head of medical devices, at the time of the inspection this post had not been recruited to.

- The trust had a Board Assurance Framework (BAF) and a corporate risk register in place, subject to a quarterly cycle of peer review through the risk assurance group, the trust executive group and Board committees. This was used to prioritise risks that the trust should review through the quality committee, with a report of the outcome to provide to the audit committee.
- The latest version of the Board Assurance Framework was agreed in October 2014 and further updated in December 2014. The risk statements on the BAF were underpinned by the risk registers and the information was used to support risk management of the delivery of the trust's corporate objectives and the annual governance report.
- The main risks on the register were with regard to the lack of staff to provide a paramedic service within the north and south of Yorkshire areas, meeting regulatory requirements regarding health and safety checks and the cleaning of vehicles, and the inability to maintain a cleaning regime for the ambulances. In addition, risks to meeting performance targets included attending red calls were considered high.
- When we visited the resilience team, including the HART service, we found that there were governance failings to ensure that the equipment, including lifesaving equipment and consumables were safe to use, with in-date products and appropriately charged. The vehicles used for a regional response also were unclean both the exterior and interior of the vehicles. This matter was raised with the trust at the time of the inspection, which acknowledged the failings and took immediate actions to make the service safe and ready to respond.
- There had been audits undertaken within the HART service, as referenced on the risk register and these had not identified the deficiencies and so no actions had been taken to address the failings.
- The trust had assessed and identified prior to the inspection the following seven areas as key challenges:
- Clinical supervision, embedding a professional culture and consistent implementation of clinical supervisor across operational areas.

Summary of findings

- Meeting increased red demand with wider system pressures such as hospital turnaround times.
- Staff engagement there was geographical issues and shift patterns across the trust, with a strong unionised culture.
- Management and leadership capacity and capability there had been a number of interim executives, historic deficit in middle to senior management capability, variation in quality and performance management across localities.
- Support functions such as Fleet and Estates teams, not always well-aligned to needs of front-line staff.
- Complaint Response times there was an increased number over 25 day target for response.
- Commissioner engagement and strategic direction the trust had to manage and work with a complex arrangement of CCG's and a lack of coherent commissioner and trust view of future regional strategy. The trust was commissioned by 23 clinical commissioning groups.
- The feedback from the lead commissioner reported that there was a much more positive working relationship developing between the trust and the commissioning bodies.
- We reviewed the trusts corporate risk register and found the trust did not have robust governance processes to manage risks in a timely and effective way. We found the pertinent risks from the risk register showed the trust had been aware of the issues for a number of years and had failed to put sufficient actions in place to minimise the risks. The trust acknowledged that there was further improvement needed to embed the processes across the trust.
- The trust reported there was a national shortage of paramedics and subsequently had significant difficulties in recruiting staff, particularly paramedics, which impacted on the ability to be responsive and also enable staff to attend training and other activities. There were concerns over places not being taken up on paramedic courses leaving shortages in the future and also that funding would not roll over into the next year. This had been on the risk register since May 2013.
- The Trust told us at the time of inspection they had significantly expanded opportunities for technicians to become paramedics and that places available were under-subscribed with the Trust actively encouraging uptake. However some staff within the trust told us they did not feel the organisation supported them to train to become paramedics.

Summary of findings

- New operational rotas increased vacancies for band 5 paramedics which left the trust unable to fill planned core operations staff shifts, with the appropriate skill mix and this impacted on red response calls. There were 23 vacancies and this was identified as a red risk on register from February 2014.
- The risk of A&E vehicle cleaning not being compliant was identified particularly in North and East Yorkshire. The actions recorded identified there was weekly monitoring, IPC audits, 141 inspections to monitor the compliance. It was identified there was a lack of availability of crew to clean within timescales, A&E vehicle checks not being done as required by clinical supervisors and three cleaner vacancies. This was identified as a red risk and had been on register since July 2012. Throughout our inspections we found there were continued concerns with the cleanliness of vehicles. Despite the risk being identified since July 2012 the trust had not managed to put an effective system in place to ensure vehicles were appropriately cleaned. Failure to complete vehicle deep cleaning procedures within the timeframe was also highlighted as an amber risk on register and had been on since September 2013.
- Concerns highlighted on the risk register in relation to health safety identified the H&S policy did not cover all areas expected such as DSE, risk assessment processes, working at height, CoSHH, arrangements in place to cover PPE selection and use, equipment, manual handling etc. Despite control measures being identified at the time of inspection this risk remained on the risk register with the same risk score though the risk had been reduced to amber.
- There was a lack of robust governance systems and processes to identify and mitigate risk within the trust

Fit and Proper Person Requirement.

- The trust had developed a policy for the Fit and Proper Person Requirement. The policy stated the fitness of directors would be reviewed on a regular basis to ensure they remain fit for the role. This would be annually for existing directors as part of their appraisal and as part of recruitment for new Directors.

Leadership of the trust

- At the time of inspection four out of the six executives were in substantive positions however there had been a recent loss of the Chief Executive and a history of change at executive level within the trust.
- The chair had been in post for approximately four and a half years and the non-executive directors had been in post throughout this period.

Summary of findings

- A Trust Board paper from the Audit Committee (8 January 2015) provided the quality committee risk assurance report. One of the key risks reported was regarding the adverse impact on clinical outcomes due to the failure to embed the clinical leadership framework into the organisation. The update reported that although there was some positive progress further work was continuing to develop and monitor an agreed dashboard.
- Key to the development and future sustainability of the trust was the Transformation Programme, at the time of the inspection the priorities within the programme were identified and further work to finalise the specific deliverables for 2015-16 was in progress. There was executive director lead, associate director lead as part of a wider portfolio and head of service transformation. The trust was planning to recruit to a newly created associate director of service transformation role which had been agreed to further strengthen the programme management arrangements
- Leadership capability, low staff engagement and the workforce not aligned to the business requirements was acknowledged by the trust as a challenge.
- The trust was preparing for Foundation Trust status and was at the pre-application stage. As part of the preparation for FT status, there has been a recruitment drive for the YAS Forum, a shadow panel of representatives, public and staff to prepare for the future configuration should FT status be approved. We saw agendas, minutes and attended a forum meeting in public on 13 January 2015.
- There was a varied picture from the ambulance crews about how visible the leadership team at board level were. Some had met the interim chief executive officer (CEO) but the majority of staff told us they had not seen or met other members of the board. One crew reported that the CEO had spent time with them on shift, which they appreciated and found valuable. Staff we spoke with generally felt the trust senior management teams were remote and simply issued commands.

Culture within the trust

- Staff reported across the trust that promotion to management had traditionally been through the ranks, with performance targets the main driver rather than quality.
- It was clear through interviewing the executive team, senior managers and professionals working within the trust that there is an ambition to move to a professional, clinical culture. Staff reported that they were proud to do their job but were under

intense pressure to meet targets, and that they were left feeling exhausted. Clinical leaders were introducing training and raising awareness wherever there were opportunities to engage with staff to create a professional base culture.

- An equality analysis of the service values based recruitment had been completed. The trust was working with NHS England's equality team to further embed the Equality Diversity System 2; the framework for this was already in place.
- The trust was undertaking a cultural audit to identify engagement issues and staff expectations of leaders and managers at team and departmental level. The cultural barometer provided a platform for the development of a new behavioural framework.
- Before, during and after the inspection staff representatives raised concerns about safety and performance at the trust. Staff side representatives reported that their members had strategic concerns over the PTS service, A&E service and Health &Safety issues in the trust. Staff members felt there had been too much change at senior management level and turnover of interim executives, with at least four directors of operations posts in a short space of time. Staff reported that they could not remember a stable team leadership since 2006. There was confidence expressed in local senior management.
- Issues raised included the lack of clinical staff, retaining staff, communication difficulties, which were in the main email based with little time to read. Staff members were reporting health problems, particularly over musculoskeletal problems and work related stress.
- The trust reported they had introduced a number of measures to address musculoskeletal problems and work related stress. There had been a replacement of equipment bags which had been an improvement in 2014. There was a further roll out of new carry chairs as an on-going programme to introduce equipment which mitigated the risk. The trust had implemented a data flagging process to highlight potential dangers and allow staff to stand off and there was work on introducing a dynamic risk assessment.

Public and staff engagement

- The Trust Board met in public every two months. The trust was undertaking the Friends and Family test and patient surveys but they were aware that they needed to reach more patients; the response rate was about 1%. The trust was working on improving patient engagement with the See and Treat patients, which had to have the FFT in place by April 2015 and this was also aligned to a CQUIN target.

Summary of findings

- The trust reported there was a monthly postal patient surveys run for all service lines, which have a much higher response rate than the newly introduced national FFT model. The trust won a national award in 2013/14 for their patient experience programme.
- The trust was developing a staff engagement strategy for 2014/15. The NHS Staff survey for 2014 only 43% of staff responded. The percentage of staff in the trust that felt that they make a difference was 88% compared to the national average of 89%. The trust scored the same as the national average of 76% of staff feeling satisfied with the quality of work and patient care they are able to deliver.
- The trust had launched a staff suggestion scheme in May 2013 called “Bright ideas” in which 264 ideas had been submitted.
- Staff sickness absence 2013/14 was above trust target. The Ambulance Service average for the month of March 2014 was 6.3%; the Sickness Absence for the trust was reported as 6.7%. In February 2014 a new absence management policy had been agreed.

The trust had a new partnership with an external company for the provision of occupational health support for staff in the trust. The trust’s employee wellbeing strategy was under development.

Innovation, improvement and sustainability

- There was uncertainty over income generation and the sustainability of some services within the trust. Arrangements were in place to hold twice a year a joint quality and financial meeting to go through the quality impact assessment process, with a non-executive director as chair.
- Key to the trust’s success to achieve its strategic aims and future development was the transformation programme. This involved the redesign of services to provide a hub and spoke arrangement, call centre integration, intelligent ambulance service, PTS transformation, urgent and emergency care delivery model.
- The trust consistently performs well against the Red 19 national target, reaching patients within 20 minutes 95.50%.
- The trust were looking at the sustainability of the PTS service. Fleet replacement was a challenge and capital options being explored.
- The trust was working on building the internal capacity for robust incident investigation and aimed to embed this in the

risk management arrangements at all levels of the organisation. In addition, the trust was implementing the new risk assessment process, including the "dynamic risk assessment" as part of the health and safety strategy arrangements.

- For security, the trust had developed a five year plan, with lock down procedures in place and included the completion of a self-review tool and audit with NHS Protect with the introduction of the new NHS security standards.
- The Emergency Operations Centre has achieved AMPDS Centre of Excellence accreditation and a member of staff had won the international 'EMD of the Year' award in 2014.
- The HART team led on the development of the national Urban Search and Rescue capability and is at the forefront of introducing extended skills to these specialist clinicians. YAS is the only ambulance Trust to fulfil the requirements of the MERIT model which was being adapted to fulfil the new guidance for mass casualty.

Overview of ratings

Our ratings for Yorkshire Ambulance Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience	Inadequate	Not rated	Not rated	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Yorkshire Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Outstanding practice and areas for improvement

Outstanding practice

- The trust's 'Restart a Heart' campaign trained 12,000 pupils in 50 schools across Yorkshire.
- The trust supported 1,055 volunteers within the Community First Responder and Volunteer Care service Scheme.
- Green initiatives to reduce carbon in the atmosphere by 1,300 tonnes per year.
- The emergency operations call centre was an accredited Advanced Medical Priority Dispatch System (AMPDS) centre of excellence.
- Mental health nurses working in the emergency operations centre to give effective support to patients requiring crisis and mental health support. This included standardised protocols and 24 hour access to mental health pathways and crisis team.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

Importantly, the trust must:

- The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure that equipment and medical supplies are checked and are fit for purpose.
- The trust must ensure all staff are up to date with their mandatory training.

In addition the trust should:

- The trust should ensure all staff receive an appraisal and are supported with their professional development. This must include support to maintain the skills and knowledge required for their job role.
- The trust should ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- The trust should ensure all ambulance stations are secure at all times.
- The trust should review the provision and availability of equipment for use with bariatric patients and staff are trained to use the equipment.
- The trust should review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- The trust should ensure records are securely stored at all times
- The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.
- The trust should all staff have received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- The trust should ensure there are appropriate translation services available for staff to use to meet the needs of people who use services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(h): Assessing the risk of, and preventing, detecting and controlling the spread of infections. We found that the trust did not always have the facilities, systems and arrangements in place to protect service users from the risk of exposure to a health care associated infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 Good governance We found the trust did not have robust governance processes to manage risks in a timely and effective way. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The trust must ensure risk management processes were effectively embedded across all regions and the quality of identifying, reporting and learning from risks was consistent.

The trust must ensure that equipment and medical supplies are checked and are fit for purpose.

The trust should ensure there is an effective system for reporting incidents and providing feedback to staff on the outcomes of investigations.

The trust should ensure records are securely stored at all times.

The trust should ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.

The trust should ensure records are securely stored at all times.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training and had an appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure there are suitable arrangements in place for staff to receive appropriate training, supervision and appraisal including the completion of mandatory training. This must include support to maintain the skills and knowledge required for their job role.